BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ELI J. HAMMER, M.D.** Holder of License No. 17176 For the Practice of Allopathic Medicine in the State of Arizona	Case Nos. MD-07-0617A MD-08-0265A **CONSENT AGREEMENT FOR DECREE OF CENSURE**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Eli J. Hammer, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. Respondent acknowledges that the long-term effects of Human Growth Hormone (HGH) used for the treatment of Adult HGH deficiency have not been

conclusively determined. Respondent further acknowledges that the FDA has approved the use of HGH only for the treatment of a disease or other recognized medical condition.

11. Respondent agrees to perform regular physical exams and lab studies after patients' initial visits prior to continuing medications and to more carefully address abnormal clinical and laboratory findings.

12. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

13. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and § 32-1451.

ELI J. HAMMER, M.D. DATED: 3/26/09

Approved As To Form:

Debra A. Hill DATED: 3/26/09

Debra A. Hill
Attorney for Respondent

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 17176 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0671A after receiving a complaint from another governmental agency concerning Respondent's prescribing practices. Subsequently, case number MD-08-0265A was initiated after the Board directed Staff to open an investigation following Respondent's admission to taking Xanax without a prescription and prescribing Xanax to a family member on two occasions.

4. Several patients presented to Respondent for various complaints including erectile dysfunction, low energy, underactive sex drive, and anti-aging therapy. Respondent evaluated the patients and prescribed various medications that included human growth hormone (HGH), testosterone, Armour thyroid, Vioxx and Voltarin XR. There was inadequate documentation that after the initial visit of each patient Respondent performed physical examinations, other than checking vital signs and body fat percentage, or ordered follow up lab studies to support the continued prescribing of the medications. There also was inadequate documentation that he monitored the patients for side effects from the medications. Additionally, there was no indication that Respondent directly discussed his prescribing with the hematologist of patients DH who had a history of acute myelogenous leukemia (AML) and JD who had a history of Non-Hodgkin's Lymphoma.

5. Further, patients CS's, JG's, JM's and MW's initial physical exam showed that their testicles appeared slightly atrophied bilaterally. Despite this, Respondent did not perform a volume measurement or document the consistency of the testicles. Patient DH contacted Respondent and reported an addiction to Diazepam and Valium. Respondent

agreed to assist him in a weaning schedule; however, there was no documentation of this agreement. On several occasions, DH contacted Respondent and requested a prescription for Diazepam and Valium. Respondent authorized several prescriptions for Diazepam within a thirty day period. Respondent also authorized several refills for excessive amounts of Valium without the structured care of an addiction specialist. For patient MC, Respondent performed a bone density test on his right hand that showed osteopenic range for females rather than males. There was no documentation of this finding and whether it was communicated to MC.

6. Patient NM contacted Respondent complaining of hand and feet numbness and tingling. Respondent gave her the option of discontinuing the GH for five days or to lower the dosage. Additionally, Respondent changed her estrogen and progesterone protocol prescribed by her gynecologist even though she did not have any complaints regarding the therapy and had good lab responses to the dosing. For patient RM, Respondent noted abnormal liver functions, a left kidney cyst, and anemia. Respondent referred him to an internist for a kidney ultrasound. Respondent also discontinued prescribing GH, but later resumed prescribing without documenting it in RM's chart. There was no documentation that Respondent communicated this with RM's internist. For patient ML, who had a history of cancer and was taking Armour thyroid and aspirin, Respondent prescribed Vioxx for his arthritis without counseling regarding gastrointestinal risks of combining Vioxx with aspirin. Respondent also did not document a joint exam to support his prescription for Vioxx. Subsequently, ML contacted Respondent complaining of palpitations. Without ordering any labs to assess his thyroid, Respondent told him to discontinue the Armour thyroid. Respondent also prescribed Ambien and Valtrex to ML without performing a physical exam or ordering any labs. Additionally, there was no documentation of a prior prescription for Valtrex. For a year, Respondent did not see ML

and he came in on March 4, 2005 and stated that he illegally acquired testosterone and GH. Despite previous documentation that ML had abused these medications, that he had acquired them illegally, and that there were no labs for over a year, Respondent resumed prescribing to him. For patient JM, there was evidence that he obtained illegal steroids; however, Respondent did not document this in JM's chart.

7. Additionally, there was inadequate documentation that Respondent followed up on various abnormal findings, including CS's and RM's elevated blood pressure; JD's and SG's elevated blood sugar levels; markers for potential cardiovascular disease for MC; CG's and ML's elevated hematocrit levels; abnormal labs significant for leukocytosis for CP; and abnormal finding of inguinal lymphadenopathy for JM .

8. On May 24, 2007, Respondent was ordered to undergo a drug test that was positive for Alprazolam. On June 8, 2007, during an investigational interview with Staff, Respondent admitted that he took a one-half tablet of Xanax without a prescription. At a second investigational interview on June 20, 2007, Respondent admitted that he prescribed Xanax to his brother-in-law (FS) on two occasions. Staff obtained pharmacy surveys that showed on May 18, 2006, FS filled a prescription for Xanax prescribed by Respondent.

9. The standard of care requires a physician to perform physical exams and lab studies prior to continuing medications; to monitor the patients for side effects from the medications; to address abnormal clinical and lab findings; to communicate any prescribing with the patient's other providers; to communicate abnormal findings or a changed protocol with the patient; to counsel a patient on the gastrointestinal risks of combining medications; and to wean a patient's Valium under the structured care of an addiction specialist when the Valium dose is greater than 20 mg per day. The standard of

care also requires a prescription from another physician for a controlled substance and to not prescribe a controlled substance to an immediate family member.

10. Respondent deviated from the standard of care because he did not perform sufficient physical exams and lab studies after the initial visits prior to continuing medications; he did not consistently address abnormal clinical and lab findings; he did not adequately communicate his prescribing with the patient's other providers; he did not communicate the abnormal findings with MC or a change in the gynecologist's protocol with NM; he did not counsel RM on the gastrointestinal risks of combining medications; and he did not wean DH from Valium under the structured care of an addiction specialist. Respondent also did not receive a prescription for Xanax from another physician and he prescribed Xanax to an immediate family member.

11. There was a risk of side effects from medications not clinically indicated, possible recurrence of DH's AML and possible withdrawal seizures with inappropriate withdrawal from Valium. Additionally, there was potential for abuse of controlled substances or overdose if FS gave misinformation and was receiving the same medication from multiple providers.

12. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because there was inadequate documentation he performed physical examinations, ordered follow up lab studies, that he resumed medications, or discussed his prescribing with other current providers.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."); A.R.S. § 32-1401 (27)(g) ("[u]sing controlled substances except if prescribed by another physician for use during a prescribed course of treatment."); A.R.S. § 32-1401 (27)(h) ("[p]rescribing or dispensing controlled substances to members of the physician's immediate family.") and A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. This Order is the final disposition of case number MD-07-0617A and MD-08-0265A.

DATED AND EFFECTIVE this 2ND day of APRIL, 2009.

(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed this 2nd day of April, 2009 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed this 2nd day of April, 2009 to:

Debra Hill
Osborn Maledon
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Phoenix, AZ 85012

EXECUTED COPY of the foregoing mailed this 2nd day of April, 2009 to:

Eli J. Hammer, M.D.
Address of Record

Kenyda Corley
Investigational Review